ZdravReform/ЗдравРеформ

Lessons Learned and Next Steps in Health Reform for Central Asian Republics

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I. INTRODUCTION

Any strategy for continuing and expanding health reforms in the Central Asian region should build on successful initiatives and incorporate lessons learned and strategies that have proven effective in the first five years of health reform implementation. This document summarizes lessons learned from implementing the two principal strategies that form the underpinning of the USAID ZdravReform Program, a comprehensive, integrated health reform model and health reform demonstrations. Based on the lessons learned from implementation of these two strategies, the document outlines possible next steps to continue and expand this effort in the future.

II. LESSONS LEARNED

A. Health Reform Model

The ZdravReform Program has implemented health reforms in demonstration sites in different ways, depending on local needs. Underlying all of the reform demonstrations, however, is a conceptual model of health reform that has a set of key components that do not vary in their relevance, although they may vary in how they are implemented. The following sections describe lessons learned from implementing the health reform model.

1. Comprehensive Definition of Health Reform Model

The first lesson that emerged from ZdravReform's early experience is that the conceptual health reform model must be comprehensive and address all aspects of the health care system. Some views of health reform focus particularly on financing reforms, because the severe underfunding and gross inefficiency of the health care system are the most visible problems. It became clear early in implementation, however, that financing reforms alone cannot bring about the fundamental changes in the delivery of health care services that are needed to improve the health of the population.

The comprehensive conceptual model that has evolved from ZdravReform implementation experience is described in detail in another document ("Conceptual Foundations for Central Asian Republics Health Reform Model"). The model contains the following four key components: service delivery restructuring and clinical strengthening of primary care, health financing and payment, population involvement, and new health information and management systems.

2. Integrated Implementation of Health Reform Model

A second lesson that has emerged is that because all parts of the health care system are intertwined, it is impossible to separate the elements of the reform model, and they must be implemented in an integrated way. As reforms are implemented in one area and changes begin to occur, other parts of the health care system are affected and must be addressed as well. For example, as new provider payment systems are introduced and economic incentives for efficiency become stronger, health facilities must have the information and management autonomy to respond to the new changes by reorganizing their services and changing their cost structures. As a further example, as resources

and service delivery are shifted to primary care, clinical protocols must be changed in order to allow primary care to provide a wider scope of services and reduce referrals.

3. Coordination of the Timing of Implementation

A third lesson from ZdravReform experience is that the timing of introducing components of the reform model is extremely important. If some elements of the reform model progress too far ahead of others, the process of integration is disrupted. One example is the timing of restructuring primary care and clinical strengthening. The restructuring of the primary care delivery system, particularly in the rural areas, is one of the least resource-intensive steps in the reform process, and therefore has often been implemented quite rapidly. Clinical strengthening occurs much more slowly, however, because it relies on freeing up resources from other parts of the health care system or on donor assistance, which is often constrained by lengthy procurement procedures. The lag between primary care restructuring and clinical strengthening can leave the newly restructured primary care system vulnerable, and may discredit the reform process. This problem is further exacerbated if new payment systems are introduced that create financial incentives for primary care facilities to provide more services before they have the clinical capability to do so.

4. Collaboration with the World Bank

The need to ensure timely material support for reforms has generated a fourth lesson, which is that the health reform model has the greatest impact and potential for success if it is supported by the resources available through World Bank loans. The USAID ZdravReform Program has actively and successfully collaborated with the World Bank in Kazakhstan, Kyrgyzstan and Uzbekistan to jointly implement the health reform model in demonstration sites in these countries.

The collaboration between USAID and the World Bank on health sector loans is an excellent opportunity to combine the material assistance of the World Bank with the technical assistance of USAID implementing partners for health reform programs. The World Bank is reluctant to lend for equipment and other capital investment without some assurance that there will be system-wide reform to ensure sustainability of the investment. The governments of Central Asia are reluctant, however, to borrow for technical assistance to implement a reform program that meets the World Bank's requirements. Providing the technical assistance through a grant to the project from USAID has proved to be an excellent solution to this dilemma. Furthermore, USAID benefits from this relationship, because the success and visibility of its health reform programs can be boosted by the injection of material assistance from the World Bank project.

B. Establishing Sustainable Demonstrations

The demonstration strategy allows working variations of the health reform model to be developed and tested in a well defined geographic and administrative area. These working models generate experience and lessons learned, which can be expanded and adapted for other sites, and eventually taken to the national level. The idea of demonstrations is not that they will be temporary activities, but that successful new

policies will be institutionalized, and their implementation will become a routine part of operating the health sector.

1. The Role of Donors in Achieving Sustainability

Lessons from USAID ZdravReform experience show that the role of donor support in achieving the goal of sustainability of health reform demonstrations is two-fold. First, donors can absorb some of the initial start-up costs of reforms that the health sectors of Central Asian countries do not have adequate human or financial resources to cover. In the early stages of reforms, the interest in and incentive to work on reform activities is often concentrated among a few individuals and is not widespread in government health institutions. Health reform activities are in addition to, rather than instead of, the routine work of health sector professionals, who are often poorly compensated and initially do not have the skills or desire to take on these tasks.

Donor-supported technical assistance can reduce the burden of early reform efforts by bearing much of the financial and time costs associated with start-up activities, such as research and development of technical products, establishing computer systems, and training. Donor-supported technical assistance can also play the role of catalyst or organizer of the oblast demonstration reform activities during the early phases. This is a vital contribution, because local partners may not initially have the organizational skills to plan what at first seem to be abstract activities, which are outside of their current scope of work. In addition, the technical assistance team can provide some cover for local partners while the reforms are still relatively unknown or unsupported beyond a small group of health sector leaders, and there may be some risks involved in change. If donor-supported technical assistance absorbs the costs of the early activities and provides organizational and political support, reforms are able to get off the ground and begin to take root, which is the first step toward sustainability.

The second role of donor support in achieving sustainability of health reform demonstrations is that of capacity-building at all levels of the demonstration: policymakers, operational and technical staff in health policy institutions, and health care workers. Although donor organizations can absorb part of the start-up costs of reforms, this should be carried out in conjunction with counterparts from the demonstration areas from the very beginning. Local partners usually do not have time to devote their full attention to early reform activities, but to begin to build capacity, they must be involved in some way in all aspects of the design and start-up.

Beyond the start-up phase, strengthening capacity in the demonstration is a gradual process, and begins to occur as counterparts start to gain interest in and the incentive to devote time and attention to reform activities. This capacity-building grows out of ongoing day-to-day implementation of the reforms and is supplemented by specific technical support and training activities conducted by donor-supported technical assistance organizations.

For successful capacity-building, it is important that the pace of reforms follow a natural progression of foundation-building and step-by-step implementation. If reforms are pushed too quickly by top-down planning and legislation, implementation gets ahead of capacity, and local partners become frustrated and are unlikely to claim ownership of the reform process. This can create a dichotomy between the daily work

of the health sector, which is carried out by health sector professionals, and health reform activities, which are carried out by technical assistance providers. If reforms are implemented gradually and allowed to follow a natural process of expansion, sustainability is more likely. Capacity-building will be more appropriate and effective, because it will be driven by demand from local partners, as the reform process becomes more stable and their roles and responsibilities become clearer.

The demonstrations also play an essential part in capacity-building beyond the demonstration oblasts, which should be supported by donor activities. As oblast counterparts participate in the design and gain experience with the day-to-day implementation of reforms, they become advocates for reforms and an important source of technical assistance for national policymakers, other oblasts in the country, and for other republics. It is important for future donor-supported health reform activities in the region to build on this tremendous resource. A mechanism should be included in future projects to financially support technical assistance from experienced local partners in the oblast demonstrations. The institutionalization of this cross-training after donor support ends should be built into the activities. In addition, future donor-supported projects should cultivate the skills and training capabilities of new reformers, so the cadre of locally-provided technical assistance continues to grow.

2. The 3 Stages of Health Reform Demonstrations

Finally, the main questions related to the sustainability of demonstrations is deciding when they are mature and how long external support should be continued. The ZdravReform Program experience shows that even after demonstrations begin to mature and are rolled out, health sector professionals throughout the country and the entire region continue to look to the demonstration for new ideas and guidance. For that reason, there is no clear endpoint for technical assistance to the core demonstrations. The core demonstrations should continue to be supported, although on a declining basis after an initial intensive period, throughout the period of donor assistance, so the reforms can deepen and continue to become more technically advanced and serve as an example for other reform activities.

ZdravReform experience from more than ten demonstrations in the Central Asian region has shown that health reform demonstrations typically pass through three distinct phases:

(1) Foundation-building;
(2) Implementation;
(3) Deepening and widening.

The foundation-building phase, which typically lasts for about one year, includes creating the legal basis for the reforms at the national level and in the demonstration area, the design and preparation of all of the elements of the reform model, training, and raising awareness about reforms among policymakers, health care workers and the population.

Establishing the legal basis for reforms requires an analysis of the current legal environment and the identification of potential obstacles to specific health reform activities. At this time, dialogue with other parts of the government that directly affect

the operation of the health sector, such as the Ministries of Finance and Labor, should be initiated to ensure their understanding of the health reform process.

Establishing the legal basis for reforms is an important opportunity to begin capacity-building at the national level to guide and manage the reform process. A strong relationship should be forged between national health sector leaders and leaders from the demonstration area. The process for feeding back results from the demonstration to national policy should be initiated during the foundation-building phase.

To build the foundation for service delivery restructuring, plans for the formation of independent primary care practices are developed and approved. Clinical strengthening also begins during this phase, as short-term clinical re-training courses are provided, and plans for equipment and renovation are developed. The process of transferring equipment from hospitals and polyclinics begins, and if new equipment will be purchased, the lengthy procurement process is initiated. Non-governmental associations may also be formed at this stage.

To begin to build the foundation for population involvement and open enrollment, a population database is established. At this time, an initial public awareness campaign should be carried out to inform the population about reforms, the new rights and responsibilities of the population, and to explain why their primary care provider may have changed.

In the area of provider payment systems, data is collected and cost analysis completed in order to design and calculate the technical parameters of the new payment systems. These steps may include budget analysis and cost accounting to determine the pool of resources currently available for primary care, and to calculate the average and relative costs for different types of hospital cases. Funds flow issues are also addressed during this phase.

In the area of information and management systems, new information systems are designed, data collection forms developed and approved, and computer training is initiated. Management training may begin, and primary care practice managers are hired and trained.

The implementation phase, which typically lasts about two years, begins when all or most of the elements of the health reform model begin to function. This phase is characterized by intensive technical assistance and training. There can be frequent and rapid changes during this period, as implementation begins to yield experience and modifications are made to how the elements of the reform model are implemented. In addition, local capacity begins to grow rapidly, and implementation decisions are increasingly driven by observations and recommendations of local partners.

During this phase, independent primary care practices are formed, and bank accounts may be opened for newly registered facilities. The independent primary care practices begin to fully function and receive independent funding. During this phase, primary care practices begin to expand their scope of services, as clinical training continues and more equipment is provided. Infectious disease and reproductive health services begin to be incorporated into primary care. The payment systems begin to function, and practice managers start working in the primary care practices. Information systems

begin to operate and are expanded and refined. Activities to increase population involvement are intensified, and open enrollment is conducted as appropriate to the local environment.

After about two years, implementation of the reform model begins to stabilize and the depth of local capacity increases. At this stage of reforms, the core demonstration is deepened by increasing the scope and technical sophistication of the reforms, and the demonstration is widened by rolling out to other geographic areas. Next steps to technically deepen the reform model are discussed in detail in the following sections. It is important, however, that the reforms also be deepened politically and institutionally through the incorporation of experience from the demonstration into national level policies.

III. NEXT STEPS

The combined lessons learned from the demonstration and health reform model strategies lead to next steps that can be taken to further advance the implementation of the health reform model in the Central Asia demonstration sites. The eleven ZdravReform demonstration sites in Central Asia are at varying degrees of maturity in terms of the scope and technical sophistication of the reforms, capacity that has been built, and the level of institutionalization of new policies. In terms of the three phases discussed above, three sites are in the foundation-building phase, six sites are early in the implementation phase, and two sites are in deepening and widening. Five sites overall are currently widening the reforms to larger geographic areas. Although the ZdravReform Program has found that widening should occur only after the demonstration has moved into the deepening phase, three of the sites that are in the implementation phase are simultaneously moving into widening, because roll-out is occurring in conjunction with a World Bank project.

The next section discusses possible next steps for deepening the components of the health reform model in the next wave of donor-supported health reform in the region. The remaining sections discuss the current status of demonstrations in each country and next steps for advancing or deepening the existing demonstrations and strategies for expanding or widening them geographically.

A. Next Steps for the Health Reform Model

1. Restructuring Service Delivery and Strengthening Primary Care

Deepening service delivery restructuring should serve to realign the outpatient specialty and inpatient sectors to adapt to a stronger primary health care sector, resulting in a more efficient health delivery system providing lower cost, higher quality health services to the population. Specific steps should include developing and testing new models of both urban and rural primary care that provide alternative ways of achieving greater autonomy for primary care providers and bringing primary care closer to the population. In addition, as the new primary care service delivery structure becomes institutionalized, more work is needed on hospital and polyclinic restructuring and strengthening to begin to integrate the entire health service delivery system. As primary care takes on a larger share of health service delivery, the case-mix faced by hospitals and polyclinics will become increasingly more complex. Future health

reform activities should therefore begin to address the changing needs for the structure and clinical capabilities of these institutions.

In the area of clinical strengthening of primary care, much work remains to deepen the clinical skills of re-trained family practitioners and to institutionalize family medicine training in the medical education system. The first generation of family medicine trainers has been trained, and many primary care physicians have passed through initial re-training cycles. Much work is still needed to continue to strengthen the clinical skills of practicing physicians, as well as to institutionalize family medicine training by creating a clear path to becoming a family practitioner from undergraduate through post-graduate residency training.

One of the most critical issues is linking the long-term retraining process of existing family physicians to the modular courses which upgrade skills, since many doctors cannot take a year off from work to attend a one year retraining course. Therefore, a system of short-term training is needed that creates a continuing education path to certification as a family physician to complement the second path, which might involve a one (or more) year dedicated training program.

The medical institutes also need more assistance in shifting to family medicine. The emphasis has been on creating the new generation of family medicine trainers. However, there has been only limited assistance on reforming the entire medical education system to make it consistent with family medicine. This includes combining separate medical institutes into a single unified school that trains general physicians.

Training for nurses and practices managers also needs to be addressed. This should include both pre-service and in-service training. Building the capacity and capability of all health care workers will strengthen the reforms by increasing the motivation and commitment of health care workers.

Deepening primary care reforms also includes continuing the integration of vertical programs into primary care. For example, the dispensary systems such as the one for sexually transmitted infections (STIs), should be rationalized and the services taken over by primary care providers, because the existence of these vertical systems continues to drain the limited resources of the system and lead to fragmented care for patients. A sustainable health care system can only be achieved by integrating services and ensuring that the limited resources available to the health sector are used properly. Training programs for control of specific infectious diseases should be integrated into the existing training system and should not be stand-alone training programs. In addition, it is necessary to begin modernization of the public health system, currently dominated by the vertical Sanitary and Epidemiology Service (SES), which has largely remained on the periphery of reforms.

As more services are integrated into primary care, the role of other medical professionals, such as laboratory workers and specialists, will be redefined. Their clinical skills and relationship to primary care physicians will need to change, and future reform activities should provide training for these professionals to help them adapt to the new environment. For example, as more prevention and case management for cardiovascular disease occurs in the primary care setting, cardiologists will treat patients only in the acute phase of illness. The role of the cardiologist in the overall

continuum of care and the relationship to the primary physician will change. Future reform efforts should focus on strengthening the relationship between primary care providers and specialists to better integrated care through all stages of prevention and treatment.

Finally, for health reform to have an impact on the quality of health care provided, profound changes are needed in the practice of medicine, including the adoption of modern treatment protocols. The lack of a tradition of evidence-based medicine and clinical epidemiology is the fundamental barrier to changing clinical practice in post-Soviet health care systems. Future work will need to focus on fundamental changes in medical education and research to bring about changes in clinical protocols, and significant re-training efforts to put the new protocols into practice.

2. Health Financing and Provider Payment Systems

In the area of new provider payment systems, deepening the reforms includes increasing the technical sophistication of the systems themselves. This may include increasing the complexity of the case groupings in the case-based hospital payment system, implementing partial primary care fundholding, introducing more complex risk adjustment coefficients for per capita payment, particularly in conjunction with partial fundholding, and developing and testing different drug reimbursement schemes.

Deepening provider payment reforms is tied to continued work on macrofinancing issues and the institutional structure in the health sector. Perhaps the single most important issue for institutionalizing new provider payment systems and allowing them to drive the rationalization of the health sector is addressing the constraints to pooling of health care funds at the oblast level and allocating health care resources without budget chapters. This requires empowering the Ministries of Health in Central Asia to be able to set policy and priorities for the health sector, clarifying the relationships between different Ministries and the levels of government, restructuring the MOH and increasing its capability to support the new health purchaser functions, and establishing a research/analysis capability within the health sector.

3. Population Involvement

One of the goals of health reform is to change the social contract in the health care system to empower the population to take a more active role in their health care decision-making. In the future, open enrollment should be expanded as independent primary care practices are established and more physicians and nurses are trained. To increase the responsibilities of the patient and establish a stronger relationship between the doctor and patient, a greater emphasis should be placed on health promotion in primary care, as well as providing more materials for patients to become better educated about how to take care of their own health.

As the reforms continue, patients gain a greater voice in the health care system as their health care choices are increasingly linked to financing through new provider-payment systems. If the money providers receive follows the choices of patients, rather than being based on guaranteed budgets related to planning norms, then provider income

becomes dependent on the demands of patients. This changes the entire power structure within the health care system by empowering patients over providers.

Other health reform activities should continue that strengthen the relationship between the population and the health care system. A grants program for joint projects between health facilitates and the community can be established and supported by technical assistance. Health care workers and the population can be trained in public health to better understand how the primary care system and the community can work together to solve health problems.

Finally, continued attention needs to be given to strengthen health sector non-governmental organizations, such as the Family Group Practice Association and the Hospital Association, which can be powerful vehicles for advancing health reforms through individual involvement at the local level and as policy advocates. These fledgling organizations can be linked to western associations to help them develop and access resources outside of the region.

4. Health Information and Management Systems

The health reform process in Central Asia is redefining how information is collected and used in the health sector. New health management information systems are generating better quality information that can be assembled and analyzed in a way that is useful to health managers and policymakers for improving clinical practices, the management of resources, and other aspects of health facility performance. The health management information systems that support new provider payment systems must be strengthened and refined. Implementation of health provider and clinical and financial management systems must be expanded.

Deepening the health information and management systems requires strengthening the link between new information and management systems to quality improvement and monitoring and evaluating the performance of all aspects of the health care system. Next steps include filling in the gaps of the information systems and linking them back to decisionmaking that improves policy formation, implementation, and the performance of individual health facilities.

There is a strong need to improve the quality of clinical data, particularly mortality data that is a useful aggregate indicator of health system performance. Mortality data, particularly data on cause of death is notoriously unreliable. The death registration system is outside of the health sector and there are no checks on what is written as the cause of death. Furthermore, the cause of death on the death certificate is not checked against autopsy data. The death registration system needs to be updated with more detailed information about death and linked to health care utilization systems.

The information that is most lacking is patient satisfaction. This should be introduced in a more systematic fashion by health facilities, health departments and health insurance funds. Survey methodology is poorly developed in the health sector and significant technical assistance is needed to improve instruments, sampling, and statistically analysis of results. Household surveys are needed to capture those who do not use health services. The introduction of household surveys is one of the most important techniques for quality improvement because it creates data that can used to

evaluate the progress of health reforms.

B. Next Steps for Demonstrations in Kazakhstan

The most mature demonstration site in Kazakhstan, Zhezkazgan, is in the phase of deepening the reforms and widening them to the entire Karaganda Oblast. To continue to deepen the Zhezkazgan demonstration, next steps include refining the payment systems to further integrate primary care, outpatient specialty and inpatient services. Additional steps may include experimenting with a drug reimbursement system, and working on more fundamental hospital consolidation, reorganization and strengthening. It will be important to continue clinical training to further expand the scope of services of the primary care practices.

Clinical strengthening should also be expanded to include polyclinics and hospitals to help them adapt to an increasingly intensive case-mix, as a greater share of less severe cases should now be treated in primary care. Population involvement should be enhanced through refining and institutionalizing re-enrollment and expanding health promotion and the integration of health promotion and public health into primary care. The health sector non-governmental organizations should continue to be developed to strengthen their role as change agents in the health sector. In terms of widening the demonstration, the Zhezkazgan reforms are already being expanded to the level of Karaganda Oblast, and as next steps should also be rolled out to Astana and possibly to Pavlodar.

Karaganda Oblast has begun to roll out the Zhezkazgan reforms at the oblast level. Over the next two years, Karaganda will be in the implementation phase, and it is important to begin to integrate all of the elements of the health reform model. A relatively sophisticated hospital payment system has been introduced for all hospitals in the oblast. In addition, Karaganda has introduced some oblast funds flow legislation that facilitates the refinement of new provider payment systems throughout the oblast. Primary care reforms, however, remain at an early stage. Although Karaganda has begun primary care restructuring and strengthening, only limited geographic areas have been covered, and clinical strengthening has not yet begun. Next steps include extensive work in clinical training, and the introduction of primary care open enrollment.

In urban and rural Semipalatinsk, the implementation phase should be completed over the next year or so. The next steps are to deepen the reforms by refining the payment systems to further integrate primary care, outpatient specialty and inpatient services, experimenting with a drug reimbursement system, and working on more fundamental hospital consolidation, reorganization and strengthening. The Semipalatinsk reforms are already being widened to all of East Kazakhstan Oblast as part of the World Bank project. Eventually, the Semipalatinsk reforms will also be widened to Almaty Oblast under the World Bank project. In East Kazakhstan, the foundation-building phase should be completed over the next year, and next steps include implementation.

It is clear at this point that Kazakhstan is moving away from a national health care system, and is instead opting for more regional variation in health financing and service delivery policy. It remains important, however, for the national level to establish a broad policy and legal framework for the health care system. Kazakhstan has made

steps toward deepening some components of the health reform model by institutionalizing them with national legislation. Examples include national level legislation that provides the foundation for implementing a case-based hospital payment system and restructuring primary care. More work is needed, however, on a more comprehensive policy and regulatory framework to guide the overall development of the health care system.

C. Next Steps for Demonstrations in Kyrgyzstan

While the Issyk-Kul Oblast demonstration site is fairly mature, it should be maintained to improve sustainability and present a visible example of health reform. It continues to serve as a test site for introducing subsequent levels of the health reform model, levels which can only be added after the preceding level is in place. For example, a strengthened primary care sector able to expand its scope of services is required before parts of the scope of service of hospitals and outpatient specialty providers can be transferred to primary health care. To deepen the restructuring of the health delivery system, a next step in Issyk-Kul Oblast is to restructure and realign the outpatient specialty and inpatient sectors to adapt to a stronger primary health care sector, resulting in a more efficient health delivery system providing lower cost, higher quality health services to the population. This requires continuing to improve the clinical capability of primary care physicians, as well as addressing the role of clinicians in other care settings such as hospitals.

Other next steps in Issyk-Kul Oblast include continuing to increase population involvement through re-enrollment and health promotion; strengthening the role of the Family Group Practice Association and other NGO's as change agents in the health sector; and refining the provider payment and information systems in order to enhance the integration of different levels of the health delivery system – primary care, outpatient speciality, and inpatient care.

Another aspect of deepening the health reforms is continuing to strengthen the national legal and policy framework. It is imperative that the major remaining issue hampering the health reforms in Kyrgyzstan be resolved, pooling budget funds at not less than the oblast level. Until this issue is resolved, so that new provider payment systems without budget chapters can be implemented using budget funds, the health reforms are not sustainable. Another next step to deepen the health reforms at the national level is continuing to implement and refine the new national provider payment systems and health information systems. Finally, issues including a long-term health financing strategy, quality improvement, strengthening public health, MOH policy development and evaluation functions, and medical and health management education must be addressed at the national level to help ensure long-term sustainability of the health reforms.

Bishkek City and Chui Oblast are in the demonstration site implementation phase, which should be completed over the next two years. Following their graduation to the demonstration deepening and widening phase, next steps include restructuring and realigning the health delivery system to adapt to a stronger primary health care sector, continuing to increase clinical capabilities of all physicians and nurses, expanding the involvement of the population through re-enrollment and health promotion, strengthening health sector NGO's as change agents, and developing health provider

capability to adapt to the new provider payment systems and improve management and quality.

In Osh and Jalal-Abad Oblasts, the demonstration foundation-building phase will be completed over the next year or so. They will graduate to the implementation phase and will require 2-3 years to complete implementation of health reforms in the four pilot sites and expand the reforms throughout Osh and Jalal-Abad Oblasts.

Naryn and Talas Oblasts are in a pre-foundation building phase. Without the provision of oblast level technical assistance, they have actually initiated the health reform process. The fact that Naryn and Talas Oblasts are initiating reforms without outside intervention is concrete evidence that the national legal and policy framework for health reform in Kyrgyzstan is developing rapidly. Naryn and Talas should move through the demonstration foundation-building phase fairly quickly due to the national impetus for health reform. This means that they should enter the implementation phase in a year or so, and they will then require approximately two years to implement health reforms.

D. Next Steps for Demonstrations in Uzbekistan

In Uzbekistan, the Ferghana demonstration, which is currently limited to three rayons in the oblast, should complete the implementation phase over the next year and a half. Next steps include deepening the rayon demonstration, and widening to the remainder of Ferghana Oblast and to Navoiy and Syr Darya Oblasts under the World Bank-financed "Health" Project.

Deepening the service delivery restructuring in Ferghana Oblast may include exploring options for increasing the autonomy of primary care providers, possibly including experiments with privatization, and adding urban primary care restructuring in the rayon centers and Ferghana city. Further deepening of clinical strengthening would include efforts to continue expanding the scope of services provided by the primary care sector. This will require further collaboration with the current ten-month re-training offered by the British Know How Fund. Additional training is needed for all health personnel including nurses and laboratory workers.

The primary care per capita payment system may be extended to the entire oblast as primary care restructuring occurs, and the payment system may be refined to integrated primary care, outpatient specialty care and hospitals services. In addition, experiments may be initiated to add primary care drug reimbursement into the per capita payment. Greater population choice and primary care open enrollment may be considered, particularly as primary care reforms extend to urban areas.

Health marketing and population involvement activities also should be expanded as primary care is increasingly oriented toward preventive medicine. Grassroots-level community involvement in the health sector by expanding the NGO and mahalla grants program linked to primary health care facilities. Vertical programs, such as preventing infectious and sexually-transmitted diseases and promoting reproductive health, also should be integrated into primary health care.

The deepening of reforms in Ferghana should also include work in the hospital sector.

Restructuring and rationalizing hospitals is currently included as part of the World Bank project, but thus far little progress has been made. To begin to drive hospital restructuring, the demonstration in Ferghana should eventually introduce a new case-based hospital payment system. The information system will be need to be refined and expanded to include a hospital case database as the reforms deepen.

Reforms also should include a systematic evaluation of pilot projects to support widening of reform efforts beyond Ferghana Oblast. Effects can be measured through the new information systems, demonstrating increases in utilization and decreases in referrals to polyclinics and hospitals. Evaluation efforts should be complemented by a repeat of a household survey to capture information on households and those who do not utilize health services.

Much work is ahead over the next five years building the foundation and widening reforms within Ferghana and to Navoiy and Syr Darya Oblasts. It will be important to continue to link the work of the demonstrations in the three oblasts with the national level, and to feed back results of the demonstration to national level policymaking.